

EMSC/CHILD READY CONNECTION NEWSLETTER

JULY 2015: VOLUME 3, ISSUE 7

A word from the EMSC Program Manager:

Greetings!

The Emergency Medical Services for Children (EMSC) Program aims to ensure that emergency medical care for the ill and injured child or adolescent is well integrated into an emergency medical service system.

We work to ensure that the system is backed by optimal resources and that the entire spectrum of emergency services (*prevention, emergency response, prehospital care, hospital care, interfacility transport, and rehabilitation*) is provided to children and adolescents, no matter where they live, attend school or travel.

THE RIGHT CARE AT THE RIGHT PLACE AT THE RIGHT TIME WITH THE RIGHT RESOURCES!

Child Ready Montana- State Partnership of Regionalized Care (SPROC)

The intent of the program is to develop an accountable culturally component and assessable emergent care system for pediatric patients across Montana.

Exciting news and events are going on this month!

What is Parens Patriae power?? See page 2

Need resources on reuniting children with families after a disaster? See page 3

What is NAS? See page 4

Challenging work brings stress- see these resources to help build a resilient workforce on page 5.

Child Seat Belts and Child Restraint information. See page 6 & 7

ICD 10 Training Resources- see page 9.

REMEMBER YOUR SUN SCREEN!



EMS & Trauma Section
EMS for Children,
PO Box 202951,
1400 Broadway,
Room C314A,
Helena MT 59620

WHAT'S NEW?

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PEDIATRIC DISASTER AND EMERGENCY RESPONSE

Which one of the following doctrines provides health care providers with the ability to treat non-life threatening issues with a child who is unaccompanied following a disaster and for whom a legal guardian cannot be located?

- A. implied consent
- B. Parens Patriae power
- C. traditional Consent
- D. legal Consent

Implied consent: This statute is also referred to as the reasonable-person standard; it applies the question of what a reasonable person would do under similar circumstances. Typically, this level of consent has been applied to individuals unable to respond (i.e., unconscious) and who have a life-threatening injury or illness that, if left untreated, would increase the probability of a poor outcome.

Parens Patriae power: Latin for parent of the nation: This power applies to patients who may not have life-threatening injuries or illness, but require minor levels of intervention. In the absence of a guardian or parent, there is acceptance that the patient falls under the care of the state. Therefore, care is authorized, reducing unnecessary extended delays while trying to locate a legal guardian.

Child Evacuation:

What would your community do if there was a gas leak that occurred near a child care facility or school?
What are the considerations for the evacuation of children?

- | | |
|---|--|
| How would you arrange transport? | What type of vehicles would be needed? |
| How would you identify each child? | How would you identify each parent? |
| What location would you transport to? | Would parents identify likely shelter sites? |
| Would you have enough water? | How would you notify parents or legal guardians? |
| Would you have enough food suitable for infants and children? | |
| What specialized equipment would you need? | |
| Would you have enough human resources to care for the children? | |

NASEMSO PEC List -

The Insurance Institute for Highway Safety (IIHS) has released ease of use ratings for child seat installation hardware in vehicles.

You can watch the video is here:

<https://www.youtube.com/watch?v=ZqSdwj9PMYk&feature=em-uploademail>

Additional information about the Lower Anchors and Tethers for Children (LATCH) evaluation is available here: <http://www.iihs.org/iihs/ratings/ratings-info/LATCH-evaluation>.

Reuniting Children with Families After a Disaster

Emergency management agencies must plan for all aspects of many different disaster scenarios. An important aspect is reuniting families who've been separated during a major national or regional disaster.

Though we like to think we have things under control, families are separated most days by school or work, and when phones and roads are severely impacted by flooding or an earthquake, locating missing loved ones is difficult.

Several government agencies and non-profits joined together to release a framework that helps state and local agencies get families back together. "[Post-Disaster Reunification of Children: A Nationwide Approach](#)" (PDF, 1.1 Mb) was written in part to encourage local agencies to consider the part they play in the process without being overwhelmed. Smaller municipalities could be mired by the range of issues and legalities involved in caring for ten or even five children for 24 to 48 hours.

Now consider the over 5,000 displaced minors after Hurricanes Katrina and Rita. One resource that eagerly responded to this problem was the National Center for Missing and Exploited Children (NCMEC). With an existing system and proven track record, they used their website to both list children found and report the missing. Retired law enforcement officers staffed the call center, ensuring the NCMEC mission to the rest of the country was not affected.

That call center worked so well it led to the design of several tools previously unavailable to state and local authorities. The [National Emergency Child Locator Center](#), the [National Emergency Family Registry and Locator System](#) (NEFRLS), and [Unaccompanied Minors Registry](#) are all available during disasters to assist authorities in the complex task of reuniting families during challenging and emotional times.



CHILD READY MONTANA

Child Ready Montana is a State Partnership Regionalization of Care Grant (SPROC) funded by the Federal Health Resource and Services Administration (HRSA). Montana is one of 6 states to be awarded this grant with the Montana Emergency Medical Services for Children (EMSC) Program.

Child Ready Montana has completed the state wide site visit assessments.

Assessments were conducted at critical access facilities, assessing pediatric emergent needs. Here are the key findings:

Eastern:

Transport & Triage Protocols
Telehealth equipped and ready
crisis debriefing

Central:

transport & triage protocols
Certification class availability
Telehealth equipped and ready

Western

Telehealth equipped/ready
Transfer protocols
Certification Class availability

*Cultural sensitivity training is needed across all regions

Please stay tuned in the future for systematic phases of regionalization of pediatric emergent care in the state of Montana. If you have any questions please feel free to contact Kassie Runsabove at 406-238-6216.

NEONATAL ABSTINENCE SYNDROME (NAS)

NAS is a collection of clinical findings associated with physical dependence on drugs and subsequent withdrawal in newborns. NAS is most commonly seen with opioid exposure, but can be seen after exposure to other drugs.

A newborn was considered to have NAS if he/she was coded in any of the primary or up to eight secondary diagnosis fields. Because of the billing nature of hospital discharge data, NAS is coded to justify more extensive care. As a result, it is well-ascertained in hospital discharge files. NAS is not coded on the Montana Birth Certificate; however, it is recorded as a complication as part of the discharge record. Because hospital discharge data is not identified, they were unable to link the discharge records of the infant with the discharge records of the mother or the birth certificate.

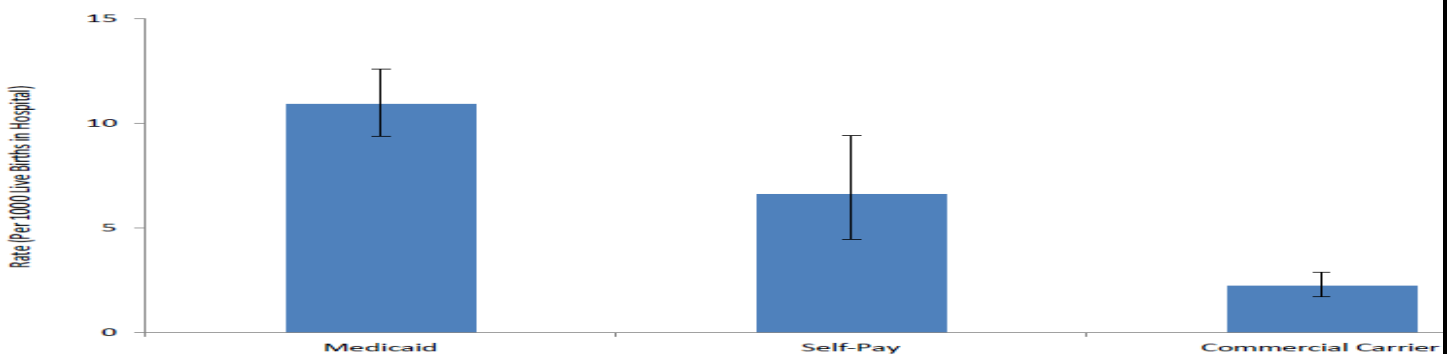
There were 432 newborn infants with NAS from 2000 to 2013. The rate of NAS in Montana newborns increased from 0.8 per 1,000 live births in 2000 to 9.0 per 1,000 (95% confidence interval 7.3% - 10.9%) in 2013 (Figure 1), a tenfold increase. **There was a consistent increase from 2006 to 2012, and then a substantial upturn between 2012 and 2013.**

The American Academy of Pediatrics (AAP) revised NAS diagnostic guidelines in 2012; the revision may explain part of the large increase seen in 2013. In spite of the substantial increase in the rate, in absolute numbers there were 96 babies coded with NAS in 2013, out of more than 12,000 live births.

Data on hospitalization charges were added to the MHDDS in 2009. For the interval 2009 - 2013, mean charges for newborns with NAS were \$34,000 versus \$6,800 for newborns without NAS. Mean length of stay for newborns with NAS was 12.1 days, almost four times the mean of 3.1 days for newborns without NAS. Twenty percent of newborns with NAS were of low birth weight (< 2500 grams) compared to 8.6% of newborns without NAS; and 26.1% of newborns with NAS were premature (< 39 weeks), compared to 13.2% of newborns without NAS. Low birth weight and prematurity both contribute to long hospital stays and increased costs even in the absence of NAS. **Infants born with NAS also often have respiratory complications and feeding difficulties and may require intensive nursing care, and between 60% and 80% require pharmacologic management.**

Sixty-percent of infants with NAS had Montana Medicaid as the primary payer. Comparing rates of NAS by primary payer, the highest rate of NAS was for newborns whose births were paid by Medicaid, 10.9 per 1,000 births, compared to 6.6 per 1,000 for self-pay and 2.2 per 1,000 for commercial insurance.

Figure 2. Rate of Newborns with Neonatal Abstinence Syndrome (ICD-9-CM: 779.5), by Primary Payer, Montana Resident Liveborns, 2000-2013



BUILDING WORKFORCE RESILIENCE THROUGH THE PRACTICE OF PSYCHOLOGICAL FIRST AID

Research shows that challenging work brings with it stress reactions that, if unaddressed, can harm individuals, families, and communities and disrupt even the best organized workplaces. The Department of Health and Human Services and the Assistant Secretary for Preparedness and Response, in partnership with NACCHO, developed [Psychological First Aid for Leaders \(PFA-L\)](#).

This **free, 90-minute interactive and effective on-line training helps leaders at any level understand and address their staff's stress risks and reactions and create a resilient workplace.** PFA-L is based on the principles of Psychological First Aid which is an evidence-informed approach for assisting children, adolescents, adults, families, and responders in the aftermath of a disaster or emergency event.

Organizations that work in emergency or disaster related areas such as public health, emergency response, hospitals and other healthcare organizations or even voluntary organizations that are active in disasters will find PFA-L useful. **Supervisors and leaders will gain skills that will help build a resilient workforce which will in turn lead to less staff turnover, fewer work conflicts, increased productivity and effectiveness in service to the mission, and overall enhanced workforce development.**

PFA-L is a scenario-based and exercise-driven course that also incorporates self-evaluation.

Training topics include:

- Lead with Compassion and Care to Build Workforce Resilience;**
- Stress Reactions in the Midst of Disaster Response;**
- Core Components of PFA;**
- Challenges and Opportunities When Providing PFA;**
- When PFA is Not Enough; and**
- Your Leadership Role in Providing PFA to Support Staff.**

Throughout the training, the trainee is presented with interactive activities representative of critical preparedness, response, and recovery responsibilities. Four teams representing operations, policy, medical countermeasures, and field deployment are depicted with accompanying scenarios and exercises throughout the course. Detailed profiles of each manager and team member allow the course trainee to follow individuals as they face a number of situations that highlight different stress risks and demonstrate PFA skills. More info can be found at <http://nacchopreparedness.org/?p=4683>.

CONTINUING EDUCATION CREDITS for Physicians; Nurses; Health Educators; and general continuing education for those courses specified below is available through the CDC Training and Continuing Education Online system (CDC TCEO). To apply for CEUs, go to CDC TCEO. For questions or problems contact: <http://www.cdc.gov/tceonline/CDC/ATSDR> Training and Continuing Education Online at 1-800-41TRAIN or email at ce@cdc.gov and follow the instructions.

Improving the Mental and Emotional Well-Being of Communities through the National Prevention Strategy: Community and Historical Trauma: Surviving and Recovering-Link to recording: <https://hrsa.connectsolutions.com/p8t93fybo6f/>

Improving the Mental and Emotional Well-Being of Communities through the National Prevention Strategy: Recognizing and Responding to Trauma: The ACE Study and Trauma-Informed Care - Link to Recording: <https://hrsa.connectsolutions.com/p8on7d5mxsa/>

Improving the Mental and Emotional Well-Being of Communities through the National Prevention Strategy: Reducing Stigma and Misunderstanding of Mental Health- Link to recording: <https://hrsa.connectsolutions.com/p9tepru2bce/>

Addressing Health Disparities through the National Prevention Strategy: The Role of Individuals and Families—Link to recording: <https://hrsa.connectsolutions.com/p51hodmqkam/>

SEAT BELTS AND CHILD RESTRAINTS

Seat belt use is the most effective way to reduce the severity of injuries in motor vehicle crashes. According to the National Highway Traffic Safety Administration (NHTSA), seat belts reduce the risk of fatal injury to front seat passengers by 45 percent and the risk of moderate-to-critical injury by 50 percent.

Experts have found that child safety seats and booster seats are effective ways to reduce the number of children hurt in car crashes. From 1975 to 2008, an estimated 8,959 lives were saved by child safety seats, booster seats and/or seat belts. Motor vehicle deaths among children (ages 12 and under) decreased by 43 percent in the past decade.

However, motor vehicle crashes are still a significant cause of death for children ages 0 to 3, and the second leading cause of death for children ages 4 to 14. More than 650 motor vehicle occupants aged 0 to 12 years died and 148,000 were injured in car crashes in 2011, and one third of the deaths were among children who were unrestrained — without car seats, boosters or seat belts.

There is strong evidence that child safety seat laws, safety seat distribution and education programs, **community-wide education** and enforcement campaigns and incentive and education programs can increase child safety seat use.

NHTSA and the American Academy of Pediatrics recommend car seats for infants and toddlers, typically until a child reaches the age of 4. Car seats should be rear-facing until at least the age of 2.

When used correctly, child safety seats can reduce fatal injuries by more than 70 percent for infants and more than 50 % for toddlers.

Booster seats typically for children ages 4 to 8, so that a seat belt will fit them properly. Without a booster seat, the seat belt typically will not effectively protect smaller children.

Properly used booster seats can reduce injuries by 59 percent. Car seats or booster seats have also been shown to reduce the risk of death for children ages 2 to 6 by 28 percent compared to using seat belts alone.

All children should ride in the back seat of cars until the age of 13.



REAR-FACING CAR SEAT

Birth up to Age 2*

Buckle children in a rear-facing seat until age 2 or when they reach the upper weight or height limit of that seat.



FORWARD-FACING CAR SEAT

Age 2 up to at least age 5*

When children outgrow their rear-facing seat, they should be buckled in a forward-facing car seat until at least age 5 or when they reach the upper weight or height limit of that seat.



BOOSTER SEAT

Age 5 up until seat belts fit properly*

Once children outgrow their forward-facing seat, they should be buckled in a booster seat until seat belts fit properly. The recommended height for proper seat belt fit is 57 inches tall.




SEAT BELT

Once seat belts fit properly without a booster seat


Children no longer need to use a booster seat once seat belts fit them properly. Seat belts fit properly when the lap belt lays across the upper thighs (not the stomach) and the shoulder belt lays across the chest (not the neck).

Keep children ages 12 and under in the back seat. Never place a rear-facing car seat in front of an active air bag.


*Recommended age ranges for each seat type vary to account for differences in child growth and height/weight limits of car seats and booster seats. Use the car seat or booster seat owner's manual to check installation and the seat height/weight limits, and proper seat use.



a safety movement from
the Montana Department of Transportation



OUR PARTNERS



Would your child die in a crash?

It's a familiar routine: strapping your child into his car seat before you get behind the wheel. But is your child really safe?

Recent studies show more than 75% of car seats are incorrectly installed.

View the [Child Passenger Safety brochure](#), and print it for later reference.

Choose the right seat

The best car seat is the one that fits your child properly; is easy to use; and fits in your vehicle correctly...

Install it properly

Choosing the right car seat is the first step, the next is to properly install it in your vehicle...

Boosters and the back seat

These are steps most parents miss: boosters until 8 and placing all children under 13 in the rear seat...

Montana Passenger Vehicle Occupant Fatalities Age 5 and Above by Restraint Use and Lives Saved Estimates

Year	Fatalities Age 5 and Above*					Lives Saved Estimates**	
	Total	Restrained	Unrestrained	Unknown Restraint Use	Percent Known Restrained*	Lives Saved at Current Belt Use	Potential Additional Lives Savable at 100% Usage
2007	204	58	144	2	29	72	42
2008	166	45	117	4	28	51	32
2009	162	57	100	5	36	74	38
2010	146	50	90	6	36	68	34
2011	164	51	109	4	32	63	43

Montana Fatalities by Crash Type

Crash Type	2007	2008	2009	2010	2011
Total Fatalities (All Crashes)*	277	229	221	189	209
- (1) Single Vehicle	194	148	147	120	127
- (2) Involving a Large Truck	31	25	24	14	32
- (3) Involving Speeding	96	72	86	68	76
- (4) Involving a Rollover	145	110	114	101	102
- (5) Involving a Roadway Departure	194	144	140	132	150
- (6) Involving an Intersection (or Intersection Related)	31	33	30	32	27

Harnessing Mobile App Technology with the Period of PURPLE Crying to Prevent Abusive Head Trauma/Shaken Baby Syndrome - The National Center on Shaken Baby Syndrome

The Period of PURPLE Crying®

A Program of the
National Center on Shaken Baby Syndrome

Harnessing Mobile App Technology with the Period of PURPLE Crying program to Prevent Shaken Baby Syndrome and Abusive Head Trauma

Period of PURPLE Crying (3)

The Letters in **PURPLE** Stand for:

PURPLE

PEAK OF CRYING UNEXPECTED RESISTS SOOTHING PAIN-LIKE FACE LONG LASTING EVENING

The word *Period* means that the crying has a beginning and an end.

Period of Purple Crying (3)

Pathways for educating parents and caregivers

Did you know that babies cry more in the first few months than during any other time in their lives and it is normal?

Did you know your baby would cry like this?

Did you know your baby would cry like this?

Mobile devices to reach new parents: rationale

- Millennials (aka Generation Y): demographic cohort born between 1980-2000 (ages 15-35).
 - "Digital natives" – Completely emerged in digital revolution, avid early adopters (Pew, 2014)
 - Approximately 85% of all babies born to this generation (US Vital Statistics, 2012) have a smartphone
 - Spend 4-5 hours per day on mobile devices

US SMARTPHONE MARKET SHARE BY AGE, OPERATING SYSTEM, AND GENDER

AGE	Android OS	iOS	Other
18-24	70.0%	28.0%	2.0%
25-34	65.7%	34.3%	0.0%
35-44	65.7%	34.3%	0.0%
45-54	70.0%	30.0%	0.0%
55-64	65.7%	34.3%	0.0%
65+	65.7%	34.3%	0.0%

Source: Nielsen

Harnessing Mobile App Technology with the Period of PURPLE Crying to Prevent Abusive Head Trauma/Shaken Baby Syndrome – The National Center on Shaken Baby Syndrome

The videos are available at <http://friendsnrc.org/connections> : The entire suite of 11 videos is now available on the **FRIENDS National Resource Center website**.

Healthy Mothers, Healthy Babies is committed to:

- Provide cribs for kids - and reduce infant mortality through our Safe Sleep for Babies - a SIDS prevention program
- Prevent Shaken Baby Syndrome by helping new parents learn about the period of PURPLE Crying and more
- Promoting parent education through Montana Children's Trust Fund so all Montanans can better ensure their families' safety, health, and well-being
- Educate public policy makers at the local, state and federal level

<http://www.hmhb-mt.org/index.php?pr=Home>



TRIVIA CONTEST:

Answer the questions & win a free EMS Field Guide which includes Pediatric Emergencies. Email rsuzor@mt.gov (1st 3 to answer)

1. What is implied consent?
2. What is NAS?
3. What does PURPLE stand for?

TRAINING RESOURCES:

ICD-10 Deadline October 1, 2015: Train Your Staff - Get Ready Now with the New CMS Quick Start Guide! While ICD-10 is almost here, you still have time to get ready.

Train staff on ICD-10 fundamentals using the wealth of free resources from CMS, which include the [ICD-10 website](#), [Road to 10](#), [Email Updates](#), [National Provider Calls](#), and [webinars](#). Free resources are also available from:

- o Medical societies, health care professional associations
- o Hospitals, health systems, health plans, vendors
- o **Identify top codes. What ICD-9 diagnosis codes does your practice see most often? Target the top 25 to start. Look at common diagnosis codes available from: [Road to 10](#)**
- o Medical specialty societies- Using the documentation available, code current cases in ICD-10. Flag any cases where more documentation is needed.



Tips

- Training for **clinical staff**-e.g., physicians, nurse practitioners, physician assistants, RNs- focus on documentation, new coding concepts captured in ICD-10
- Training for **coding and administrative staff**-e.g., coders, billers, practice managers-should focus on ICD-10 fundamentals
- You can review your super bills, encounter forms, and practice management system reports to identify your most commonly used ICD-10 codes
- You don't have to use 68,000 codes-as you do now, your practice will likely use a very small subset of ICD-10 codes
- You will use a similar process to look up ICD-10 codes that you use with ICD-9
- While crosswalks from ICD-9 to ICD-10 can be useful references, ICD-10 codes should be based on the clinical documentation rather than selected from a crosswalk.
- Practices that do not prepare for ICD-10 will not be able to submit claims for services performed on or after October 1, 2015.

To learn more about getting ready, visit cms.gov/ICD10 for free resources including the Road to 10 tool designed especially for small and rural practices, but useful for all health care professionals.

